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SENATE BILL 1346 By
Cooper

HOUSE BILL 1066
By Head

AN ACT to amend Tennessee Code Annotated, Title 56, Chapter 7, Part 23 and Title 68, Chapter 140, Part 3, relative to payers of health care benefits.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, Part 23, is amended to add the following as a new section to be appropriately designated:

Section 56-7-23__. (a) (1) "Cost-sharing" means any deductible, coinsurance amount, copayment, or other out-of-pocket payment that an enrollee is responsible for paying with respect to a health care item or service covered under a health plan.

(2) "Emergency medical condition" means a medical condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(A) placing the person's health in serious jeopardy,

(B) serious impairment to bodily functions, or

(C) serious dysfunction of any bodily organ or part.

(3) "Emergency services" means:

(A) health care items and services furnished in the emergency department of a hospital, and

(B) ancillary services routinely available to such department to the extent that such items are required to evaluate and treat an emergency medical condition (as defined in subdivision (2)) until the condition is stabilized.

(4) "Enrollee" means, with respect to a health plan, an individual enrolled with the health plan.

(5)(A) "Health plan" refers to any plan or arrangement (other than a plan or arrangement described in subdivision (B)) that provides, or pays the cost of, health benefits, whether through insurance, reimbursement, or otherwise including TennCare and other plans administered by the state government.

(B) A plan or arrangement is described in this subdivision if it is:

(i) Coverage only for accidental death or dismemberment;

(ii) Coverage providing wages or payments in lieu of wages for any period during which the employee is absent from work on account of sickness or injury;

(iii) A Medicare supplemental policy (as defined in section 1882 (g)(1) of the Social Security Act);

(iv) Coverage issued as a supplement to liability insurance;

(v) Workers' compensation or similar insurance;

(vi) Automobile medical-payment insurance;

(vii) Coverage for a specified disease or illness, or

(viii) A long-term care policy.

(6) "Participating" means, with respect to a physician or provider, a physician or provider that furnishes health care items and services to enrollees of a managed care plan under an agreement with the plan.

(7) "Prior authorization determination" means, with respect to health care items and services for which coverage may be provided under a health plan, a

determination, before the provision of the items and services and as a condition of coverage of the items and services under the plan, that coverage will be provided for the items and services under the plan.

(8) "Stabilized" means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result or occur before an individual can be transferred in compliance with the requirements of section 1867 of the Social Security Act.

(b) A health plan that provides any coverage with respect to emergency services shall cover emergency services furnished to an enrollee of the plan:

(1) without regard to whether or not the provider furnishing the emergency services has a contractual or other arrangement with the plan for the provision of such services to such enrollees, and

(2) without regard to prior authorization.

(c) A health plan that provides any coverage with respect to emergency services:

(1)(A) shall determine and make payment in a reasonable and appropriate amount for such services (including services required to be provided under section 1867 of the Social Security Act), and

(B) subject to subdivision (2), may not impose cost-sharing for services furnished in a hospital emergency department that is calculated in a manner (such as the use of a different percentage) that imposes greater cost-sharing with respect to such services compared to comparable services furnished in other settings.

(2) A health plan may impose a reasonable copayment (as determined in accordance with rules established by the Commissioner of Commerce and Insurance) to deter inappropriate use of services of hospital emergency departments.

(d)(1)(A) If an enrollee of a health plan received emergency services from an emergency department pursuant to a screening evaluation conducted by a treating physician or other emergency department personnel and pursuant to the evaluation such physician or personnel identified items and services (other than emergency services) promptly needed by the enrollee, the health plan shall provide access twenty-four (24) hours a day, seven (7) days a week, to such persons as may be authorized to make any prior authorization determinations respecting coverage of such promptly needed items and services.

(B) A health plan is deemed to have approved a request for prior authorization for such promptly needed items and services of such physician or other personnel.

(i) has attempted to contact such a person for authorization

(aa) to provide an appropriate referral for the items and services, or

(bb) to provide the items and services to the enrollee, and access to the person has not been provided (as required under subdivision (A)), or

(2) If a physician (or, in the case of a managed care plan, a participating physician or other person authorized to make prior authorization determinations for the plan) refers an enrollee to a hospital emergency department for evaluation or treatment, a request for prior authorization of the items and services reasonably furnished the enrollee pursuant to such referral shall be deemed to have been made and approved.

(A) Approval of a request for a prior authorization determination (including a deemed approval under subdivision (aa) or (bb)) shall be treated as approval of any health care items and services required to treat the medical

condition identified pursuant to a screening evaluation referred to in subdivision (1)(A).

(B) A health plan may not subsequently deny or reduce payment for an item or service furnished pursuant to such an approval unless the approval was based on information about the medical condition of an enrollee that was fraudulent.

SECTION 2. If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to that end the provisions of this act are declared to be severable.

SECTION 3. This act shall take effect upon becoming a law, the public welfare requiring it.